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REPORT OF THE EXECUTIVE DIRECTOR FOR 2004: PROGRESS IN IMPLEMENTING THE MULTI-YEAR FUNDING FRAMEWORK, 2004–2007*

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* The collection and analysis of current data required to present the Executive Board with the most up-to-date information has delayed submission of the present document.

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Executive summary

1. This is an interim progress report on the implementation of the 2004–2007 multi-year funding framework (MYFF). The MYFF has two central components: a strategic results framework (SRF) and an integrated resources framework. The results framework (see annex 1) sets out three long-term goals for UNFPA in the areas of: (a) reproductive health; (b) population dynamics and poverty; and (c) gender equality and the empowerment of women. The MYFF specifies outcomes for each of these goals, defines the indicators to measure progress and identifies strategies used to achieve results. The integrated resources framework estimates the resources required in order for UNFPA to achieve results.

2. Results framework. The review of the first year of implementation of the 2004–2007 MYFF gives an overall positive assessment of the contributions made by UNFPA to achieve the MYFF results. The Fund has increasingly been engaged in policy work and has strengthened partnerships with Governments, United Nations agencies, donors and civil society organizations to achieve common results. UNFPA country offices have increasingly participated in poverty reduction strategy paper (PRSP) processes and sector-wide approaches (SWAps) to incorporate reproductive health and gender issues.

3. Positive contribution was made to ensure that reproductive health services are more available, accessible and of better quality. The Fund assisted Governments to expand family planning services, improve maternal care and prevent HIV/AIDS among women and adolescents. UNFPA has contributed to building national capacity to improve the availability of reproductive health commodities, including with regard to forecasting and distribution. UNFPA has also played a strategic role in bringing together Governments and civil society organizations in an effort to increase access to and use of reproductive health services.

4. Progress in building national capacity to collect and use data for monitoring and evaluation of national development plans, including PRSPs, is also reported. A number of countries have established sex-disaggregated population-related databases and monitoring systems to track progress in implementation of national policies, including PRSPs, and Millennium Development Goals (MDGs). UNFPA has also facilitated the consideration of population and poverty linkages in the formulation of these national development plans and policies.

5. UNFPA has played a leading role in increasing attention to gender-based violence, gender equality and women's empowerment issues. The Fund has been active in promoting the adoption of policies and setting up mechanisms to monitor and reduce gender violence and promote gender equality, including through civil society partnerships.

6. The present report uses data and information gathered from internal reporting instruments, notably annual reports of country offices, country technical services teams (CSTs) and headquarter units. Data are available for the qualitative outcome indicators, country programme output indicators and managing-for-results indicators. However, obtaining updated data for most of the quantitative goal and outcome indicators continues to be a challenge. In spite of this limitation, the report presents evidence of UNFPA contributions toward SRF results.

7. Managing for results. UNFPA is building a more robust results-based management culture by strengthening organizational effectiveness. The multiple measures adopted by UNFPA to make the Fund a results-oriented, effective and accountable organization are having positive effects. The strengthening of country offices and CSTs; the adoption of a competency-based staff performance appraisal and development system; emphasis on the quality of programming; and a stronger accountability system have boosted UNFPA

capacity to deliver results. With respect to the managing-for-results framework, the report presents the baselines for indicators reflecting the five managing-for-results dimensions identified in the 2004–2007 MYFF. Progress in these indicators will be assessed in 2007.

8. Resources framework. The report gives an update of the income estimates over the MYFF period and proposes a revision of the resource requirements for 2004–2007, given the increases reflected in the income projections during the first year of the MYFF implementation.

9. Strategic considerations. The report concludes with a review of strategic considerations for the remaining MYFF cycle. It stresses that in order to accelerate progress towards the goals of the International Conference on Population and Development (ICPD) and the MDGs, the Fund needs to strengthen its strategic alliances with key partners, linking its programmes more closely to national policy development and poverty reduction efforts. The report also identifies areas in which the Fund plans to focus greater attention to enhance its contributions to development outcomes.

I. INTRODUCTION

10. As per Executive Board decisions 2004/7 and 2004/20, UNFPA was requested to report on the MYFF in 2005 covering the first year of MYFF implementation and to present a cumulative report in 2007. UNFPA has harmonized the timing of MYFF reporting with UNDP and UNIFEM. This interim progress report outlines the Fund's key contributions in assisting countries in implementing the ICPD Programme of Action, ICPD+5 key actions and achieving the MDGs. Section II discusses the internal and external context in which UNFPA operates. Section III reports on UNFPA progress in achieving MYFF strategic results and presents good practices in implementing the MYFF programming strategies. Section IV focuses on managing for results and presents a set of lead indicators to assess UNFPA organizational effectiveness. Section V reports on the integrated resources framework. Section VI highlights lessons learned and discusses strategic considerations for implementing the MYFF in the remaining years of the current cycle. Elements for a decision are contained in section VII. Annex 1 presents a matrix of the MYFF SRF outlining UNFPA goals, outcomes, indicators and strategies. Annex 2 delineates the links and benchmarks of ICPD, ICPD+5, other international conferences and the MDGs.

II. CONTEXT

11. The environment in which UNFPA works to implement the ICPD Programme of Action continues to change. The global survey[1] conducted to assess ICPD implementation after 10 years shows steady progress in several areas. Many countries have taken a range of legal, policy, and programmatic measures to translate the Programme of Action goals and recommendations into relevant action. Increasingly, population factors are being integrated into national development frameworks; many countries are promoting gender equality and the empowerment of women, and strengthening reproductive health policies; and more programmes have been established to address the reproductive health needs and rights of people, including women and adolescents. However, in spite of this progress, significant gaps still remain, as indicated in various sections of this report.

12. The Millennium Declaration and the MDGs provide a framework to orient development efforts, as well as the opportunity to highlight the relationship between poverty reduction, reproductive health and rights, population, gender equality and development. The strategic results framework of the 2004–

[1] *Investing in People: National Progress in Implementing the ICPD Programme of Action 1994-2004*, UNFPA, New York, 2004.

2007 MYFF clearly articulates the interrelationships of the Fund's programme priorities with ICPD goals, ICPD+5 targets and the MDGs. As reflected in annex 2, the 2004–2007 MYFF is squarely positioned to contribute to achieve the ICPD goals and the MDGs. The organic links between these international development frameworks have been highlighted in the report released in March 2005 by the United Nations Secretary-General, *In larger freedom: towards development, security and human rights for all*, which stresses that gender equality, education and health, including reproductive health, are critical investments and political priorities. The Millennium Project report[2] revealed the interdependence between population dynamics, reproductive health, gender equality and poverty reduction, as well as the centrality of ICPD to eradicating poverty and achieving the MDGs. The Millennium Project Task Forces' reports[3] also emphasized that gender equality cannot be achieved without guaranteeing women's sexual and reproductive health.

13. During the celebration of the tenth anniversary of ICPD in 2004, the international community reaffirmed its commitment to the ICPD Programme of Action and underscored its inextricable link to the MDGs. Support for the ICPD and for the UNFPA mandate were unequivocally expressed by developing and developed countries at many country and regional meetings, at the thirty-seventh session of the Commission on Population and Development, and during the fifty-ninth session of the General Assembly. In October 2004, parliamentarians and government ministers from 90 countries met in Strasbourg, France, at the 2004 International Parliamentarians' Conference on the Implementation of the ICPD Programme of Action to review progress and reaffirm their commitment, including issuing the Strasbourg Statement of Commitment. Also in October, European Union development cooperation ministers attending a meeting near Maastricht, the Netherlands, reaffirmed reproductive health and rights as central to efforts to combat poverty and underlined the importance of the ICPD Programme of Action for achieving the MDGs. The ICPD tenth anniversary events helped to strengthen regional and country level partnerships with government policy makers, parliamentarians, civil society organizations, United Nations agencies and donors and to enlist their commitment for accelerating the implementation of the ICPD Programme of Action and the MDGs.

14. In 2004, UNFPA continued to participate actively in the United Nations reform process to promote a coherent and coordinated system-wide response to development needs and priorities. At regional and country levels, the Fund has contributed to the common country assessment (CCA) and United Nations Development Assistance Framework (UNDAF) processes, bringing to the United Nations common agenda key population, reproductive health and rights and gender equality issues. UNFPA programming guidelines have been revised to include the United Nations joint programming guidelines. Following the issuance of United Nations Development Group (UNDG) Guidelines on Joint Programmes in March 2004, and additional guidance from UNFPA, an increasing number of UNFPA country offices are engaging in this modality to improve the effectiveness of their support to national priorities. Because of the relatively recent issuance of guidance, a comprehensive system is not yet in place to provide detailed reporting on joint programmes.. However, based on 2004 country office annual reports and other information, it is possible to provide a general view of how UNFPA is adopting this modality. While the vast majority of UNFPA country offices can be considered to be *programming jointly* with other members of the United Nations country team (through collective processes such as the UNDAF) and increasingly with other partners, *joint programmes* – defined as activities with a common work plan among two or more United Nations agencies – are only now

[2] *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals*, UN Millennium Project, 2005.

[3] Expanding access to sexual and reproductive health services, including family planning and contraceptive information and services; closing funding gaps for supplies and logistics; and focusing on women's and girls' health and education outcomes and freedom from violence have been included among the 'Ten Key Recommendations' and 'Quick Win' solutions to be implemented without delay to make headway to achieve the MDGs.

becoming more widespread. Globally, some 75 joint programmes are either ongoing or planned and are undertaken with a wide range of United Nations partners. The most frequent partners are UNICEF, UNDP and WHO, but it is interesting to note that there are joint programmes with many other United Nations entities including UNHCR, UNIFEM, WFP, UNAIDS, UNESCO, United Nations-Habitat, UNOCD, FAO and UNIDO. The main areas of joint programming are support to health services, data for development, adolescent reproductive health, safe motherhood, prevention of HIV/AIDS and combating gender-based violence. As requested in decision 2005/10, a comprehensive report on the implementation of joint programming will be submitted to the Executive Board at the annual session 2006.

15. As a result of the implementation of a joint action plan signed in 2003, UNFPA and the World Bank have strengthened their partnership to make their inter-agency collaboration more strategic and with a focus at the country level. A review of this partnership undertaken in 2004, showed increased inter-agency collaboration in **Bangladesh**, **China, Djibouti, Jamaica**, **India**, **Indonesia**, **Philippines**, **Ukraine** and **Yemen**. Key areas of inter-agency collaboration have been: incorporating reproductive health issues in PRSPs and health SWAps, promoting youth development, building political commitment to reproductive health issues, addressing the needs of indigenous populations, increasing the availability of reproductive health commodities and reducing maternal mortality. The review of the partnership also identified areas where both organizations would pay further attention to increase collaboration to include reproductive health and gender issues in poverty reduction strategies, improve political commitment for reproductive health and maternal health, build capacity in data collection and analysis, and promote HIV/AIDS prevention.

16. UNFPA is fully committed to implement the agreements of the "Paris Declaration on Aid Effectiveness" adopted at the High-Level Forum in March 2005 by ministers and high-level officials of 85 developed and developing countries and heads of 20 multilateral and bilateral development organizations. UNFPA is working to further align its technical and financial support to the needs and priorities of countries, focusing on strengthening national capacities and systems, and promoting national ownership of development processes and outcomes.

17. Conflict, political crises and natural disasters are ever present and increasingly complex. Many of the countries in which UNFPA works experience devastation at the individual and community levels, including the destruction of social and health infrastructures. This adversely affects reproductive health and increases gender-based violence and sexual abuse against women and girls. In 2003, UNFPA was involved in interventions in more than 40 countries related to emergency preparedness, natural disasters, conflict and recovery. Many of these crises are ongoing. In 2004, new crisis situations emerged in eight countries[4] including those affected by the tsunami in December. In coordination with other United Nations agencies, UNFPA has made strong efforts to respond to these crisis situations by adapting its programmes and interventions to address the needs of the most vulnerable, particularly women and girls.

18. In response to the 26 December 2004 tsunami, UNFPA focused its assistance on ensuring access to reproductive health, including safe childbirth, prevention of violence against women and girls, and psychosocial counselling. In **Indonesia**, working with the Ministry of Health, UNFPA helped to re-establish basic reproductive health services, provided training and equipment, restored health infrastructure, established a referral system for obstetric emergencies, and supported counselling and other psychosocial services in the hardest hit districts of Aceh province. In **Sri Lanka**, the Fund provided support to assemble and distribute hygiene packs for displaced women and girls, along with

[4] Grenada, India, Indonesia, Islamic Republic of Iran, Jamaica, Maldives, Sri Lanka and Thailand.

emergency reproductive health supplies to serve a displaced population of one million. In **Thailand**, the Fund is expanding its collaboration with the Ministry of Health and non-governmental organizations (NGOs) to ensure quality maternal and child health and family planning services for displaced populations. In **India**, the Fund provided funds for maternal and neonatal health equipment and supplies, and is supporting psychosocial counselling for women and adolescents. To protect mothers and infants in the **Maldives**, UNFPA helped to ensure skilled assistance during delivery and has supported the repair and re-equipment of hospitals and health centres to restore reproductive health services.

19. In November 2004, UNFPA held its third global meeting in which more than 200 staff from the field and headquarters participated. The meeting helped to position UNFPA to meet the population and development challenges of the next 10 years. Key recommendations reaffirmed the principles of the Fund's strategic direction and the aims and strategies of the MYFF, and proposed practical actions with regard to the UNFPA role in integrating the ICPD agenda into national policy dialogues, including PRSPs, health SWAps and Millennium Development Goal reports (MDGRs). The meeting stressed the need to mobilize stronger partnerships with other United Nations agencies and development partners, and highlighted the need to carry out more effective environmental scanning to guide the Fund in the changing environment, including with regard to the United Nations reform process. The global meeting also looked into UNFPA organizational effectiveness and made specific recommendations for moving towards a more effective, efficient and accountable organization. The global meeting recommendations have been reflected in the management plans of all UNFPA units.

III. STRATEGIC RESULTS FRAMEWORK: ASSESSING PROGRAMME RESULTS

20. The SRF sets out organizational results at goal and outcome levels: the Fund contributes to these with other development partners.[5] Assessing UNFPA results at the goal and outcome levels is problematic because of issues of attribution and aggregation. UNFPA contributes to these results along with many other partners and the results obtained by countries cannot be combined to provide a meaningful measure of overall progress. To deal with this challenge the present report has made an effort to highlight specific contributions UNFPA has made toward the achievement of SRF outcomes. The SRF matrix is presented in annex 1.

21. The present report provides baselines for the qualitative outcome indicators and for the managing-for-results performance indicators. The Fund's contribution will be assessed against these in the cumulative report in 2007. The present report also provides information on progress on some institutional output indicators of the first MYFF that are closely linked to some of the outcomes of the second MYFF.

22. Lack of up-to-date and comparable data on many of the quantitative goal and outcome indicators has limited the discussion of progress on indicators. Continued investment in building national capacity to collect sex-, age-, income-, rural and urban-disaggregated data, as well as the analysis and utilization of such data, should be considered a priority area for Governments, UNFPA and other development partners.

23. To improve the Fund's capacity to track and report on results, UNFPA revised its annual reporting mechanisms to simplify them and improve their results orientation. A MYFF impact tracking system (i-Track) was put in place, which allowed for country office annual reporting to be done online,

[5] The SRF has three goals, one each in the areas of reproductive health, population and development, and gender equality and women's empowerment; and a set of six outcomes to which UNFPA programmes contribute through their country level outputs.

and facilitated the storing of MYFF-related information for monitoring, reporting and trend analysis. Data included in the present report comes from 110 country office annual reports (90 from countries which have UNFPA-supported country programmes), nine CST annual reports and reports from headquarters divisions and offices.

24. Strategic focus and effectiveness of UNFPA assistance. In 2004, country offices aimed to achieve 557 outputs in the different programme areas. Of these, 60 per cent were in reproductive health, 29 per cent in population and development and 11 per cent in gender equality and women's empowerment. About 33 per cent of the country programme outputs specifically contribute to incorporating population, reproductive health and gender issues in national development plans and policies, including PRSPs and health SWAps. This reflects the priority placed by UNFPA in policy dialogue and addressing gender issues, as specified in the Fund's strategic direction. Section V of this report presents information about expenditures made in 2004 in these programme areas (see also DP/FPA/2005/7, Part I, Add. 1).

25. UNFPA country programmes are being tailored to country needs and emerging issues and, at the same time, reflect a clear movement toward the progressive implementation of the Fund's strategic direction. The distribution of country programme outputs by region provides an interesting picture. In Africa, the proportion of outputs related to utilization of population-related data (MYFF outcome iv) and empowerment of women and gender equality (MYFF outcome vi) are comparatively higher than in other regions. Latin America and the Caribbean region presents a high proportion of outputs (40 per cent) on advocacy and the policy work either in reproductive health or in national development policies. The Arab States and Asia and the Pacific regions have higher proportions of outputs supporting the provision of reproductive health services. The Arab States and Europe and Latin America and the Caribbean regions are working to a greater extent with communities to strengthen their demand for reproductive health.

Reproductive health

MYFF Goal 1: All couples and individuals enjoy good reproductive health, including family planning and sexual health, throughout life.

26. Promoting reproductive health and rights is central to the UNFPA mission. It is captured in the MYFF by three outcomes: (a) a supportive policy environment that promotes reproductive health and rights; (b) access to comprehensive reproductive health services is increased; and (c) demand for reproductive health is strengthened. The Fund has consistently invested more than two-thirds of its financial resources to promote reproductive health.

27. A review and appraisal of the progress made during 1994–2004 in achieving the ICPD Programme of Action goal of universal access to reproductive health, shows varying progress both among countries and among population groups within countries. Many countries have established reproductive health programmes, enabling a rise in modern contraceptive use among couples, indicating greater access to family planning. While use of modern methods is around 54 per cent in developing countries, many births in those countries are still unwanted or mistimed, and modern family planning methods remain unavailable to large numbers of couples. Unmet needs for family planning remain a major concern in many countries. Adolescent reproductive health behaviour has become an emerging global concern. The HIV/AIDS crisis threatens development and the social and economic gains made in previous decades, and has worsened the mortality and morbidity situation in at least 53 of the most affected countries.[6]

[6] The population and health related data in paragraphs 27, 46, 59, 66, 79 and 92 have been drawn from the following

Progress on Outcome (i): Policy environment that promotes reproductive health and rights

28. The activities supported by UNFPA in 2004 show alignment with the MYFF framework and strategies. At global, regional and country levels, UNFPA focused on combining the strategies of advocacy and policy dialogue with strengthening partnerships. As a result, UNFPA enjoyed numerous policy successes, as increasing numbers of country offices were involved in key national partnerships working on PRSPs, health SWAps and MDG reporting. Increased advocacy efforts also prompted important advances in youth-related policies, including legislation on legal age of marriage; increases in national budgets for reproductive health commodities; and advances in gender equity policies. UNFPA made progress in 2004 in increasing its involvement at the country level in PRSPs, health SWAps and MDG reporting to advocate for a key result: the incorporation of reproductive health and gender issues in these key national development initiatives. These broader national development partnerships offer unparalleled opportunities to generate greater political support and larger investments for reproductive health activities at the country level. The overall progress in outcome indicators is outlined below.

29. Incorporation of reproductive health and gender in poverty reduction strategies.[7] An analysis of 29 PRSPs[8] developed to date shows increased attention to both reproductive health and gender issues in more recently prepared PRSPs. Almost 60 per cent of PRSPs developed in 2003 or later (post-2003) incorporate key reproductive health issues compared to 53 per cent of PRSPs developed before 2003 (pre-2003). The proportion of post-2003 PRSPs including key reproductive health-related indicators in the monitoring and evaluation plan was substantially higher than for pre-2003 PRSPs. The incorporation of gender dimensions was also greater for post-2003 PRSPs.

30. A closer examination of the reproductive health and gender issues included in PRSPs reveals a relative lack of attention to adolescent sexual and reproductive health and to emergency obstetric care, a key strategy for averting maternal deaths. Gender-based violence has also received little coverage, which is a cause for concern as the economic, social and health-related costs -- for women, their families and social and economic development -- are believed to be considerable. The incorporation of gender dimensions is generally adequate, with the notable exception of gender analysis in the discussion of reproductive health. In the future, UNFPA will focus increased advocacy around the importance of addressing emergency obstetric care, adolescent sexual and reproductive health, gender-based violence and gender-related reproductive health issues in PRSPs; and make recommendations that can be translated into concrete multisectoral plans, budgets and interventions.

31. In 2004, UNFPA country offices were increasingly engaged in the PRSP process. In countries with a PRSP developed in 2003 or later, or with a PRSP under development, 12 out of 23 country offices reported significant involvement to incorporate reproductive health and gender issues into the PRSP. In **Armenia**, for example, a key result cited by the country office was the 20 per cent increase in the PRSP budget for obstetric and reproductive health care from the previous year, with additional projected increases. Significant involvement was also reported in advancing the role of civil society in

sources: MDG Statistical Annex, United Nations, 2005; *World Population Prospects*, 2004 Revision, United Nations, 2005; and *World Contraceptive Use*, United Nations, 2003.

[7] MYFF SRF indicator.

[8] As of December 2004, 44 full PRSPs had been prepared. The sample size for the Fund's analysis was 29 PRSPs for the following reasons: six PRSPs were in countries where UNFPA did not have country programmes; four PRSPs had already been concluded; one country had suspended its PRSP; and in the case of four others, the UNFPA country offices had not submitted data.

the PRSP process. Country offices in **Armenia**, **Djibouti**, **Mozambique**, **Nicaragua** and **Uganda** specifically reported on successful advocacy interventions in PRSP partnerships.

32. Overall, it is clear that UNFPA has strengthened its efforts to mainstream population issues and reproductive health into the national poverty-reduction strategies of the poorest countries. This is the first step. To consolidate this positive trend, UNFPA plans to strengthen staff abilities to link reproductive health, population and gender issues with the broader issue of poverty reduction, and proactively seek opportunities for UNFPA participation in this nationally led process.

33. Incorporation of reproductive health and gender in sector-wide programmes in health.[9] As is to be expected in a partnership focused on the health sector, the level of inclusion of reproductive health and gender issues in SWAps is considerable. In 2004, country offices reported on 27 health SWAps in various stages of implementation.[10] UNFPA country offices actively participated in all 27 SWAps. Out of 10 SWAps being implemented, five incorporated comprehensive discussion of key reproductive health issues, five SWAps included key reproductive health-related indicators in their action plans and four incorporated gender dimensions.

34. In 2004, country offices reported that in **Bolivia**, **Cambodia**, **Egypt**, **Ghana**, **India**, **Lebanon**, **Mongolia**, **Uganda** and the **United Republic of Tanzania** important progress was made in incorporating support for reproductive health, gender, and in some cases, adolescent reproductive health into health SWAps. In **India**, for example, UNFPA participated in the design of the health SWAp – the Reproductive and Child Health Programme – providing support to define strategies for gender mainstreaming and adolescent reproductive health. In **Bangladesh**, **Ethiopia**, **India**, **Mongolia**, **Mozambique**, **Papua New Guinea** and the **United Republic of Tanzania,** UNFPA chaired technical committees or led the work in indicator development, annual reviews, implementation plans, or working groups. In the SWAps that were under discussion in 2004, UNFPA was active and played a leading role in a number of these processes.

Table 1: Involvement of country offices in health SWAps

	Number of country offices
Some level of participation (*out of all SWAps*)	27
Participation in committees, technical or reference groups (*out of SWAps being implemented or in planning stage*)	18
Participation in basket/pooled funding (*out of SWAps being implemented*)	4

35. Of the four country offices participating in basket funding – **Ghana, Mozambique, United Republic of Tanzania** and **Zambia** – three expressed a positive experience with the arrangement. Although UNFPA contributed a small amount of funds to the basket, it has helped in being recognized as a legitimate partner. The adherence to government reporting and financial procedures have reduced the administrative load for the concerned Government and for UNFPA, and allowed the Fund's staff more time to be involved in policy dialogue, advocacy on gender, reproductive health and rights, and to leverage more resources. Offices that have pooled funds have raised concerns regarding accountability, delays in financial reporting and uncertainty about the extent to which reproductive health is being covered from the pooled investments -- issues that are being addressed with donor partners.

36. To strengthen the Fund's capacity to participate actively in SWAps and other national dialogues and development frameworks, UNFPA staff developed a knowledge asset on SWAps to inform the

[9] MYFF SRF indicator.

[10] As of December 2004, 27 SWAps were reported to exist in countries in which UNFPA supported a country programme. Out of these, 11 SWAps were being implemented, 10 were in a planning stage and six were under discussion.

Fund's contribution to these processes. In addition, important progress was made in the area of reproductive health costing, an important aspect of UNFPA involvement in SWAps, PRSPs and health-sector reform. UNFPA plans to prepare operational guidelines to facilitate the work of country offices on SWAps.

37. Incorporation of reproductive health and gender into Millennium Development Goal reports.[11] An analysis of 60 MDGRs[12] showed greater incorporation of reproductive health and gender issues in more recently developed MDGRs. About one half of the post-2004 MDGRs include in-depth discussion of key reproductive health issues, while a substantial proportion also incorporate key gender dimensions. The increased attention to reproductive health and gender issues may in large part be due to expanded advocacy by UNFPA and its partners. However, a relative lack of discussion of emergency obstetric care, adolescent reproductive health and gender-based violence, as well as reproductive health analysis from the gender perspective indicates that UNFPA and its partners need to focus greater attention on ensuring a comprehensive reflection of reproductive health and gender issues in the MDGRs.

38. In 2004, many countries were actively participating in the MDGR preparation. In countries with an MDGR developed in 2004, or with an MDGR under development, 25 out of 42 country offices reported significant engagement in advocacy to increase attention to reproductive health and gender issues in the MDG reports. For example, in **Ethiopia**, the country office highlighted the connections between population, development and gender equity and supported the drafting of the gender-related sections of the needs assessment, thus ensuring that gender was well reflected in all thematic areas. In **Uganda**, UNFPA served as the chair of the gender thematic group and ensured that population, gender and HIV/AIDS issues featured prominently in the report.

39. National and subnational policies to increase the access of youth to quality reproductive health information and services.[13] Encouraging results were achieved in this area, building from the Fund's strategic focus on advocacy and policy dialogue. Fourteen countries approved new policies in 2004 designed to increase access to services for adolescents. In 12 of these countries, UNFPA country offices had a significant intervention to promote effective policy design and in 10 cases promoted the involvement of civil society in the policy design process. In **Nicaragua**, UNFPA has worked with local governments to create municipal action plans, and increased access to education and services. In **Peru**, the Congress approved the Law of Adolescent Pregnancy forbidding expulsion of pregnant girls from schools. However, analysis of the design and level of implementation of these policies shows that passage of the policy is only the first step in a longer-term process of expanding adolescents' access to information, education, and services. Given the need for fuller implementation of policies, country-level assessments are needed to identify strategies to promote implementation, enhance monitoring and improve effectiveness.

40. National and subnational laws and policies to delay age at marriage.[14] Early marriage is closely linked to maternal mortality, since statistically, it is young women who are at higher risk of dying during pregnancy. In 2004, country offices reported the existence of a legal minimum age of marriage in 87 countries. However, the legal age was below 18 in 37 countries.[15] In many countries customary

[11] MYFF SRF indicator.

[12] As of December 2004, approximately 73 MDGRs had been prepared in countries where UNFPA supports a country programme. Of this total, 60 country offices reported data on the most recently prepared MDGR, and were thus included in the sample. The sample comprised 31 'pre-2004' MDGRs (those prepared before 1 January 2004), and 29 'post-2004' MDGRs (those prepared thereafter).

[13] MYFF SRF indicator.

[14] MYFF SRF indicator.

[15] The 1989 *Convention on the Rights of the Child (CRC)* defines all human beings below 18 years of age as children.

or religious laws supersede the statutory or common/judicial law in relation to the legal marriageable age and enforcement of laws remains a challenge. In 2004, seven country offices reported interventions to promote full implementation and/or enforcement of laws and policies to delay the age at marriage, including the legal marriageable age, while in six countries UNFPA made significant efforts to promote their regular monitoring. UNFPA will continue to support Governments to strengthen their capacity to enforce existing laws to delay the age at marriage, and to advocate with religious and cultural leaders to mobilize their support to this end.

41. As part of the Fund's advocacy campaign to focus attention on the issue of married adolescents in the development and health policy agendas, in 2004, the Fund organized a panel discussion at the Global Health Council that was widely covered by the international media; it also developed an advocacy package on married adolescents, including a video "Too Brief a Child: Voices of Married Adolescents", filmed in Bangladesh, Burkina Faso and Yemen, as well as a set of supporting information documents to be used in advocacy efforts by UNFPA country offices and partners.

42. Allocation of health budget to contraceptives.[16] This is a key policy-level indicator for the sustainability at the country level of reproductive health commodity security initiatives. Reporting in 2004 showed that this data is not available in many countries because contraceptives are not a separate line item in the budget, or because purchasing is decentralized to the state level. However, important progress at the country level can be verified. Thirteen country offices reported increases in the concerned Government's 2005 budget for contraceptives, and many other UNFPA country offices report active advocacy to increase this line item in the budget and to follow-up its implementation.

43. In **Bolivia**, UNFPA involvement in the health sector reform process helped ensure that access to contraceptives was included in the new health law. **Paraguay** increased its budget for family planning supplies by 600 per cent. Since 2004, **Uganda's** PRSP has made provisions for the acquisition of contraceptives for 50 per cent of women of reproductive age. **Kenya** and **Pakistan** agreed for the first time to include a budget line item in the national budget for procurement of contraceptives. In the **Philippines**, advances have been possible at the provincial level, and as a result of UNFPA advocacy efforts, nine provinces allocated substantial sums for reproductive health supplies. The **Syrian Arab Republic** signed an agreement to increase its contribution to contraceptive procurement from 15 per cent to 50 per cent. **Nepal** has been increasing its contribution by 10 per cent each year. Concrete commitments to increased contraceptive procurement were also made by **Kazakhstan**, **Swaziland**, **Togo** and **Zimbabwe**. However, in many countries UNFPA is either the major or the sole provider for contraceptives, and continued advocacy and partnerships are necessary, especially in the least developed countries (LDCs), to increase the commitment of both donors and Governments to allocate sufficient resources to purchase contraceptive supplies.

Progress on Outcome (ii): Access to comprehensive reproductive health services is increased

44. UNFPA has long supported strengthening national capacities to increase access to the full range of high-quality reproductive health services.[17] The Fund's strategy to contribute to achieving this outcome has focused on reducing maternal mortality and morbidity; addressing unmet need for family planning; preventing sexually transmitted infections (STIs), including HIV/AIDS; and promoting

[16] MYFF SRF indicator.

[17] These services include the provision of family planning; maternal health care, including emergency obstetric care; prevention and management of reproductive tract infections, including sexually transmitted infections and HIV/AIDS; management of the consequences and complications of unsafe abortion; and information, education and counselling on reproductive health, including human sexuality and responsible parenthood.

adolescent sexual and reproductive health. Given that most indicators under this outcome do not have up-to-date information, the present report will discuss the overall situation taking into account the information available and will focus on the role played by UNFPA to contribute to the achievement of results in the different areas of intervention outlined above.

45. Increasing access to comprehensive reproductive health services relies on a cost-effective capacity-building strategy of adding new services to existing ones and improving the quality of services. Such integration demands that UNFPA focus intensively on the MYFF strategy of systems development. Accordingly, UNFPA has increased its involvement in the development and implementation of clinical protocols, standards of practice, and appropriate information and counselling in maternal health, family planning and HIV and STI services. At the primary health-care level, in 2004 the Fund continued its support to improve the availability of comprehensive reproductive health services: 64 countries with UNFPA-assisted programmes reported that 60 per cent or more of service delivery points offered at least three key reproductive health services, an 8 per cent increase since 2002.

Table 2: Availability of reproductive health services [a/]

	2002		*2004*	
	#	%	#	%
Number and proportion of countries with at least 60 per cent of service delivery points (SDPs) offering a minimum of three RH services [b/]	59	79	64	85
Number and proportion of countries with at least 60 per cent of SDPs offering a minimum of three modern methods of contraception	55	70	60	86

[a/] Percentages are of countries reporting data for the indicator in 2002 and 2004.
[b/] Corresponds to ICPD+5 Key Action 53: 60 per cent of SDPs should offer a range of RH services by 2005, 80 per cent by 2010, and 100 per cent by 2015.

46. Reducing maternal mortality and morbidity. Saving mothers' lives and protecting them from serious complications associated with pregnancy and childbirth are moral and human right imperatives and a crucial international development priority. The latest maternal mortality statistics from the Millennium Project are based on 2000 levels, and show that while the developing country average is 450 deaths per 100,000 live births, two regions have considerably higher averages – sub-Saharan Africa at 920 and Southern Asia at 540. In all other developing regions maternal mortality ratios range from between 55 and 240 per 100,000 live births, considerably lower than the average. These averages, however, conceal inequalities within regions and within countries.

47. Under the Averting Maternal Death and Disability project in collaboration with Columbia University, UNFPA supported projects in **India**, **Morocco**, **Mozambique** and **Nicaragua** to increase the availability and use of emergency obstetric care. These projects have emphasized training of medical and paramedical staff, and strengthening national monitoring and evaluation systems. UNFPA is completing needs assessment in eight other countries. The emergency obstetric care project in Rajasthan, **India**, is a successful model that was scaled up to the state level, and has been adopted as part of the reproductive and child health programme (SWAp).

48. Fifty-four country offices reported working to increase access to skilled attendance at birth. Of these 42 mainly invested in training new providers, and 14 provided routine obstetric equipment. In many countries, emergency obstetric care is a new type of service outside of urban areas, and the Fund's contribution was diverse, with substantial support to training, equipment and supplies, services, and referral systems, including transportation. UNFPA has made major transport investments in **Côte d'Ivoire**, **Kenya** and **Zambia**. **Papua New Guinea** is building a knowledge base for decision-making through maternal mortality audits. **Uganda** reported a scaling up of the RESCUER emergency obstetric care referral system, with a critical mass of qualified service providers resulting from significant investments in protocols and training.

49. In 2004, UNFPA continued its leadership in the campaign to end fistula which focuses on preventing fistula from occurring; treating women who are affected; and helping women who have undergone treatment to reintegrate back into their communities. The campaign is now active in over 30 countries in sub-Saharan Africa, South Asia and the Arab States region. Needs assessments were conducted in 17 countries and more than 10 countries have begun implementing national strategies to eliminate fistula. UNFPA has mobilized partnerships with the private sector, and support for the campaign has also grown among individual donors. New funding ($3.5 million) was obtained from the Human Security Trust Fund for programmes in **Mali**, **Nigeria** and **Pakistan**. As part of the global campaign, in early 2005, UNFPA launched the Fistula Fortnight, a special two-week project that resulted in 545 women receiving free surgical treatment at four sites in northern **Nigeria** from a team of volunteer Nigerian expert surgeons and international doctors.

50. Family planning. Historically, the outcome of increasing access to voluntary family planning services has been at the heart of the Fund's mission. Since many countries have institutionalized family planning programmes in the national health systems, most UNFPA country offices support advocacy to increase national investment in family planning services and expand choice of methods; interventions in reproductive health commodity security to improve availability of methods; and capacity-building interventions, such as developing systems for protocols, monitoring, and evaluation. Some country offices support extension of services to underserved populations such as adolescents, men, and rural isolated populations. At the primary health-care level, in 2004, the Fund continued to improve availability of modern contraception: 60 countries reported that 60 per cent or more of service delivery points offered at least three modern methods of contraception, a 9 per cent increase in the number of countries compared with 2002 (see table 2 in the report).

51. Out of 64 country offices that contributed to increased access to modern family planning, two thirds highlighted support provided to contraceptive procurement, distribution, and/or measures to increase reproductive health commodity security. Several highlighted the introduction of female condoms. Other interventions include training and information, education and communication (IEC). Community-based distribution programmes are also being supported in numerous countries, including **Burundi**, **Cambodia**, **Cameroon**, **India, Liberia**, **Malawi**, **Pakistan**, **Rwanda**, **Swaziland**, **Thailand**, **Togo** and **Zambia**.

52. In **Bhutan**, a national health conference supported by UNFPA and other development partners endorsed emergency contraception as a contraceptive method; soon afterwards, the Government announced the introduction of emergency contraception in its national reproductive health programme in 2005. In **Peru**, UNFPA provided support to the Ministry of Health to introduce emergency contraception within the minimum services package in the country and provided 150,000 cycles of emergency contraception pills. Several country offices reported partnerships that enhanced the impact of UNFPA support, including a large social marketing project in **Pakistan** with the United Kingdom Department for International Development (DFID) and the Government.

53. UNFPA country offices in 36 countries reported that female condoms were available in those countries, mostly in urban areas, but level of usage was generally low. UNFPA initiated a project for female condom programming with pilots in **Cambodia**, **India**, **Papua New Guinea** and **Sri Lanka**. Partners have been engaged and 20 countries identified for the project, to be expanded over several years. Country offices reported that in **Azerbaijan**, **Cape Verde**, **Djibouti**, **Guinea Bissau**, **Liberia**, **Mali**, **Mozambique**, **Uzbekistan** and **Venezuela** there were intensive investments in the development of family planning protocols, demonstrating a commitment to quality of care.

54. At the global and regional levels, UNFPA collaborated with WHO to improve the quality of services for family planning and STIs by increasing the utilization of WHO guidelines and tools. Regional workshops were held with representation from UNFPA, WHO and Governments, and activities were subsequently implemented at the country level in all regions.

55. The Africa, Caribbean and Pacific (ACP) Reproductive Health Programme supported by the European Commission stands out as an innovative intervention to assist the Governments of eight African and two Caribbean countries -- **Burkina Faso**, **Equatorial Guinea, Ethiopia, Ghana, Guinea Bissau, Jamaica, Niger, Rwanda, Suriname** and **United Republic of Tanzania** -- to increase national capacities to provide integrated reproductive health services to their populations.

56. Reproductive health commodity security. Improving reproductive health commodity security is a key strategy for reducing the unmet need for family planning and for preventing HIV/AIDS and STIs. It is also an example of the MYFF strategy of developing systems for improving performance. In 2004, UNFPA successfully advocated for the reproductive health commodities security initiative, which received nearly $85 million in pledges. With a view to institutionalizing these contributions, a reproductive health commodity security thematic trust fund was established. The trust fund will be geared to increasing national capacity in countries to plan, store, manage and distribute commodities to ensure a sustainable supply of commodities and prevent shortfalls.

57. The reproductive health commodity security initiative creates sustainable capacity at the national level through support for planning and procurement of adequate supplies and for systems of commodity management, with tools such as the Country Commodity Manager (CCM) and the logistics management information system (LMIS) to ensure a sustainable supply and prevent shortages. As part of this initiative, UNFPA launched the second edition of the CCM software, developed to help countries keep track of their stocks and shipments of contraceptives and other reproductive health commodities. Sixty-six countries use the software, which has proved to be a useful tool for improved national programming towards reproductive health commodity security.

58. As a result of the reproductive health commodity security initiative, country offices in **Guatemala**, **Myanmar**, **Nigeria**, **Paraguay** and **Zimbabwe** reported reductions in stock outs and also reported results related to improved ability to forecast commodities needs and manage the distribution system. Thirty-one offices highlighted concrete instances of improved planning and logistics, with **Lao People's Democratic Republic**, **Turkmenistan** and **Venezuela** reporting national coverage through new commodities management systems.

59. HIV/AIDS and STIs. In 2004, an estimated 39.4 million people were living with AIDS, with 4.9 million newly infected persons -- half of whom were aged between 15 to 24. Women comprise 57 per cent of those infected in sub-Saharan Africa, where rates in most countries are still rising. Eastern Europe and Asia are experiencing the fastest growing epidemics in the world. Reliable data on youth's condom use at last high-risk sex[18] remains unavailable in many countries, due to the political and cultural sensitivities surrounding sexual behaviour in general, and particularly that of adolescents. Data from sub-Saharan Africa and Latin America and the Caribbean show usage rates of around 25 per cent for females and between 41 to 43 per cent for males while usage in Southern Asia is considerably higher at 51 per cent and 59 per cent, respectively. Data on the proportion of the population aged 15-24 with comprehensive correct knowledge of HIV/AIDS[19] is available for countries in Africa and for some countries in other regions. The very low level of knowledge among adolescents and youth about how to prevent the transmission of HIV is of serious concern.

[18] United Nations General Assembly Special Session on HIV/AIDS (UNGASS-HIV/AIDS) and MYFF SRF indicator.
[19] UNGASS-HIV/AIDS and MYFF SRF indicator.

60. UNFPA has focused strategically on three core areas in its response to HIV/AIDS: the prevention of HIV infection among young people; the prevention of HIV infection in pregnant women; and comprehensive condom programming that includes advocating for increased condom use (correct and consistent) by sexually active young people. UNFPA is advocating for ensuring that HIV/AIDS and reproductive health and family planning are linked to reach vulnerable groups, particularly women and young people, which will also make services more comprehensive and cost-effective. This integration also needs to be reflected in national plans and budgets, including health sector reforms and poverty-reduction strategies.

61. In addition, to address the feminization of the AIDS epidemic, UNFPA re-branded one of its core areas as "Women and AIDS" and undertook several key efforts with partners in 2004. Early in the year UNAIDS, UNFPA and other partners launched the Global Coalition on Women and AIDS (GCWA) and at the XV International AIDS Conference (Bangkok, July 2004) UNFPA, UNAIDS and UNIFEM launched the publication *Women and AIDS: Confronting the Crisis* which drew attention to this critical issue. Within the coalition, UNFPA is the lead agency for the theme "Preventing HIV in Women and Girls", in partnership with the International Planned Parenthood Federation (IPPF) and Positive Youth. UNFPA will continue to expand advocacy and programming partnerships through the GCWA.

62. In partnership with WHO, UNFPA worked to address the sexual and reproductive health needs of HIV-positive women, through the development of the draft guidance module for sexual and reproductive health on HIV-positive women and the publication of *HIV Prevention in Maternal Health Settings: Programming and Training Guides*. UNFPA also published a package of planning and evaluation tools for prevention of mother-to-child transmission (PMTCT) interventions, as well as a publication entitled *Integrating HIV Voluntary Counselling and Testing Services into Reproductive Health Settings: Stepwise Guidelines for Programme Planners, Managers and Service Providers*.

63. UNFPA played a key role in global advocacy among parliamentarians, recognizing that leadership and political will are key elements for an effective response to the HIV/AIDS pandemic. In partnership with regional parliamentarian groups for population and development, UNFPA organized three subregional parliamentarian forums on HIV/AIDS. The first was held in June 2004 in Trinidad for Parliamentarians from English and Dutch speaking Caribbean countries. It resulted in the *Port-of-Spain Parliamentary Declaration of Commitment on HIV/AIDS* and a set of country-specific action plans for the next year. Similar forums were held in Thailand and Fiji.

64. UNFPA was instrumental in promoting the integration of reproductive health with HIV/AIDS and STI services and the elimination of constraints caused by vertical programming in these two areas. The *Glion Call to Action on Family Planning and HIV/AIDS in Women and Children* issued in May 2004 at a meeting organized by United Nations agencies, including UNFPA, stressed that in order to achieve internationally agreed development goals, it is vital that the linkages between family planning and PMTCT be strengthened. Building on the Glion meeting, a high-level meeting in June 2004 was organized in partnership with UNAIDS and Family Care International. This meeting resulted in *The New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health*, which established an HIV/AIDS-Sexual and Reproductive Health Working Group on programme guidance. The working group will develop policy and programmatic tools to support countries to implement the linkages between reproductive health and HIV/AIDS programmes recommended by the *Call to Commitment*.

65. As with maternal health care and family planning, scaling up high-quality services in HIV/AIDS and STIs necessitates a high level of attention to developing and implementing protocols

and guidelines. In 2004, 46 programme countries had an existing protocol for HIV/AIDS that was used at least in some service delivery points, while 56 countries had a similar protocol for STIs. In 2004, many country offices supported the formulation of HIV and STIs protocols and training of health providers to use them. In several countries, including **Ethiopia**, **Honduras**, **Lebanon**, **Philippines**, **Senegal**, **Sri Lanka** and **Uzbekistan**, UNFPA supported outreach programmes aimed at vulnerable groups.

66. Adolescent sexual and reproductive health. The ICPD 10-year review identified sexual and reproductive health as one of the top priorities in ICPD implementation. Adolescent sexual and reproductive health is a cross-cutting issue in the MYFF framework, which emphasizes preventing both HIV/AIDS and early pregnancy among young people. The latest figures from the Millennium Project show the average adolescent fertility rate for developing regions to be 64 per 1,000, with the highest rates in sub-Saharan Africa, Latin America and the Caribbean, and Southern Asia. Youth between the ages 15 to 24 comprise half of the 14,000 HIV infections occurring every day. In some parts of sub-Saharan Africa, young women are now up to six times more likely than young men to be infected with HIV.

67. The Fund's priority focus on adolescents shows increasing support to reproductive health services and information that respond to adolescents' needs for confidentiality, privacy and convenient hours. Many countries support adolescent and youth programmes to build a supportive environment, combined with behaviour change communication (BCC) interventions, and availability of youth-friendly reproductive health services. In 2004, 52 country offices reported contributions to increasing youth's access to reproductive health services. The majority of these contributions came in the form of technical assistance to Ministries of Health, and the supply of commodities. In 17 countries UNFPA offices reported support for the establishment of youth centres for reproductive health interventions, although only a handful had scaled-up national programmes. Twelve other country offices reported investments in youth-friendly services, while nine supported peer education strategies.

68. Some country offices remarked on the high costs in time and resources associated with establishing adolescent-friendly services, while others pointed out the need for more investment to ensure quality. Finding appropriate service delivery models to reach adolescents, particularly unmarried and/or rural adolescents, continues to be a challenge worldwide. More support for monitoring and evaluation of these service models is important to identify the ones with highest impact on youth's sexual and reproductive health for the least cost, since high-cost models will not be sustainable in most developing countries. This is an area in which UNFPA will further concentrate its attention.

69. Two initiatives in 2004 increased young people's input into UNFPA global and regional programming for adolescents. The Fund established an international Youth Advisory Board in 2004, which provides input to UNFPA on its regional and global work with adolescents. In addition, the Special Youth Programme recruits interns between 20-24 years of age who join UNFPA headquarters in New York. The interns provide youth perspectives for the development of youth policies. At the same time, they have an opportunity to strengthen their leadership skills. After three months at UNFPA headquarters, they return to their home countries and have the opportunity to work for a similar period in the respective UNFPA country office.

70. UNFPA institutionalized a working relationship with MTV, the television company, by joining an existing partnership to work on MTV's Staying Alive Campaign, the largest global HIV/AIDS awareness-and-prevention campaign for young people. The Fund's primary input is to assure a gender-sensitive approach in the campaign's programming.

71. Regional initiatives count on partnerships with United Nations agencies, international agencies, and local NGOs. An Asian-Pacific regional strategy on enhancing adolescent sexual and reproductive health was developed with WHO and UNICEF and outlined long-term action plans. The Reproductive Health Initiative for Young People in Asia (RHIYA) programme continues the successful collaboration between UNFPA, the European Union, and European and local NGOs towards improving adolescent sexual and reproductive health of the most vulnerable populations in South and South-East Asia. The African Youth Alliance (AYA) programme has the objective of improving adolescent reproductive health and reducing the spread of HIV/AIDS in **Botswana**, **Ghana**, **Uganda** and the **United Republic of Tanzania** in partnership with Pathfinder International and the Program for Appropriate Technology in Health. UNICEF and UNFPA regional meetings in Cairo and Tunis discussed coordination of work plans for adolescent sexual and reproductive health in the Middle East and North Africa, in partnership with UNAIDS, WHO, and the International Federation of Red Cross and Red Crescent Societies. The final phase of discussions will take place in 2005.

72. The Youth Peer Education Electronic Resources (Y-PEER) initiative in Eastern Europe and Central Asia, which is being expanded to the Arab States and other regions, has become an example of integrated behaviour change communication, which utilizes the interest and commitment of boys and girls, aided by the use of modern communication technologies, to promote gender equality and prevent HIV/AIDS and other STIs among thousands of young people. In 2004, Youth NET-Family Health International, the United States Agency for International Development (USAID), the British Council and UNICEF partnered with UNFPA to support the Y-PEER national networks that resulted in the organization of 46 different events in 15 countries gathering 220,000 youth and reaching through rollout activities 1.7 million young people in Eastern Europe and Central Asia.

Progress on Outcome (iii): Demand for reproductive health is strengthened[20]

73. Strengthening demand for reproductive health is crucial in making reproductive health policies and programmes work for the poor and other disadvantaged groups. To this end, the Fund's efforts have been directed towards empowering women, adolescents and communities, and involving men to promote access to sexual and reproductive health education and services. Such empowerment can be promoted through community-level civil society partnerships, taking advantage of, or advocating for, citizen participation mechanisms to ensure access to culturally acceptable and high quality education and services.

74. National and subnational mechanisms that advance civil society participation in planning and monitoring quality reproductive health services.[21] Through civil society partnerships, UNFPA has played a strategic role in working with both the health sector institutions and civil society organizations, in efforts to increase access to and use of services. Country offices reported that in 58 countries these partnerships either exist, or are under development. The nature of these mechanisms reported by country offices was diverse. The majority were various types of multisectoral committees and commissions, such as national reproductive health or population committees, health services management committees, HIV/AIDS coordination committees, local users committees and commissions on maternal mortality or quality of care.[22] UNFPA has been actively promoting these partnerships.

[20] This section will focus on the efforts made by UNFPA to strengthen civil society partnerships for promoting reproductive health. The other two indicators under this outcome have been discussed in the gender and adolescent sexual and reproductive health sections.

[21] MYFF SRF indicator.

[22] Examples of these mechanisms include the SRR Citizen Surveillance Working Group (Peru), Community Urban Health Services Management Committee (Côte d'Ivoire), health mutuals (Rwanda), and Reproductive Health and Human

About 30 country offices reported promoting the functioning of these mechanisms, advocating for adequate resource allocation for their implementation and expanding the coverage of issues addressed by these partnerships.

Table 3: Adoption of gender-sensitive reproductive health curricula in schools [a/]

	2002		*2004*	
	#	%	#	%
Number and proportion of countries with at least 60% of primary schools that have adopted RH curricula	8	50	27	68
Number and proportion of countries with at least 60% of secondary schools that have adopted RH curricula	12	57	26	60

[a/] Percentages are of countries reporting data for the indicator in 2002 and 2004.

75. Working with religious leaders. UNFPA supported several interventions to work with religious leaders in order to build support for sexual and reproductive health and gender issues. In **Bangladesh** 28,000 religious leaders were trained in reproductive rights and reproductive health, HIV/AIDS and gender issues. A conference of imams was organized by UNFPA and attended by the Prime Minister of Bangladesh. At the conference, the imams expressed strong support for reproductive health, safe motherhood and gender issues. Many of the imams are taking up these subjects in their sermons. **Afghanistan** convened a national consultative conference on HIV/AIDS with 160 prominent religious leaders from 34 provinces, securing agreement on their important role in the fight against HIV/AIDS, as well as on a tentative action plan. **Djibouti**, **Ethiopia**, **Kyrgyzstan**, **Madagascar**, the **Occupied Palestinian Territory**, **Sudan** and **Turkey** also reported consensus-building interventions among religious leaders. **Thailand** reported success with the acceptance of a sexual and reproductive health education programme by some of the conservative Muslim religious leaders in the southern provinces. **Uganda** included HIV/AIDS voluntary counselling and testing in prenuptial counselling guidelines of the Anglican Church; and the Uganda Supreme Muslim Council expressed support for condom use by married couples for HIV/AIDS prevention. In **Botswana**, 36 churches endorsed the implementation of adolescent sexual and reproductive health programmes in the church.

76. Male involvement. One effective strategy to increase access to comprehensive services is to involve men by integrating family planning with STI/HIV/AIDS education and services in institutions such as the military and the police. With UNFPA assistance the **Central African Republic** carried out a knowledge, attitude and practice (KAP) survey on HIV/AIDS/STIs among the military and police, resulting in commitments among authorities to support prevention and service programmes. Eight country offices reported supporting implementation of national level programmes with the armed forces in **Belarus**, **Fiji**, **Georgia**, **Nicaragua**, **Paraguay**, **Turkey**, **Ukraine** and **Venezuela**. UNFPA-supported clinics in the **Philippines** and **Honduras** reported significant increases in male use of sexual and reproductive health services; in **Honduras**, men comprise 35 per cent of all clinic visits. Support for comprehensive services for men should increase in coming years in the military and police forces, as well as in workplaces, and labour unions. These sexual and reproductive health programmes situated in preponderantly male institutions also offer a relatively unexplored opportunity for large-scale interventions to prevent gender-based violence.

77. Gender-sensitive reproductive health curriculum in primary and secondary schools. Twenty-seven countries with UNFPA-assisted programmes reported that at least 60 per cent of primary schools had adopted gender-sensitive reproductive health curricula, compared with eight in 2002. Data for the secondary level show a similar pattern, with 26 countries reporting that secondary schools had adopted gender-sensitive reproductive health curricula, compared with 12 in 2002. The increase in the number

Development NGO network (Mongolia). Women's civil society organizations are better represented and involved in these mechanisms than youth and pro-poor civil society organizations.

of countries working to improve the school curricula is indicative of the renewed strategy to reach young boys and girls in the school system.

78. The support provided by UNFPA was mainly concentrated on curriculum development or design, publishing of training manuals and educational materials, and expansion of the coverage of pilot programmes. The strong focus on curriculum development and revision relates to the introduction of gender-sensitive content, and to the latest evidence about the importance of skills-building and participatory approaches in adolescent and reproductive health educational programmes. Thirty-seven country offices reported working with national partners and United Nations agencies, like UNESCO and UNICEF, to introduce gender-sensitive reproductive health curricula into primary schools, while 45 country offices contributed to the same objective in secondary schools.

Population and Development

MYFF Goal 2: Countries address interactions between population dynamics, sustainable development and poverty, including the impact of HIV/AIDS

79. The gap between rich and poor nations remains unacceptably wide. Since 1990, only modest progress has been made to reduce poverty, and progress registered since 1990 in this MDG goal was mainly due to the rapid economic growth and social reforms in South-East Asia rather than specific progress across regions. In sub-Saharan Africa, almost half of the population lives in poverty and in Southern Asia, it is one-third. While global life expectancy has increased, progress is not uniform and many countries have witnessed stagnation in life expectancy gains, if not an actual decline, mainly due to the re-emergence of certain diseases and the growing HIV/AIDS epidemic. UNFPA support for population and development activities is critical for advancing poverty reduction efforts at the country level, given the close synergy between population dynamics, reproductive health and gender equality with poverty reduction.

Progress on Outcome (iv): Utilization of age- and sex-disaggregated population-related data is improved

80. UNFPA experience globally proves that the availability of relevant and reliable disaggregated data is vital for planning poverty reduction strategies; implementing and monitoring strategic interventions; and, more importantly, identifying vulnerable groups, including women, young people, and older populations. An analysis of 70 national development plans indicate that more than half include an adequate set of time-bound indicators and targets for monitoring progress. However, more effort needs to be made to disaggregate these indicators and targets in order to assess the impact of development interventions on different population groups such as women and adolescents. In 2004, 48 country offices reported having promoted the use of data for monitoring and evaluation of national development plans, including PRSPs. UNFPA was instrumental in building commitment and capacity of national counterparts to use data, and in promoting the undertaking of scheduled surveys.

81. Population and housing censuses. In 2004, a number of countries in Africa, Asia, and Latin America were at various stages of implementing population and housing censuses. UNFPA was actively involved in building capacity for conducting censuses and in providing technical assistance for planning, mobilizing resources, analysing the data, disseminating the results and promoting their utilization by policy makers in at least in 13 countries.

82. In the **Sudan,** the Fund supported development of the census proposal that was adopted by the Government as the major document for resource mobilization. In **Nigeria,** UNFPA worked with other United Nations agencies, bilateral partners and the European Union in the preparation of the 2005

census. In **Afghanistan**, **Bhutan** and **the Lao People's Democratic Republic**, UNFPA helped the Governments prepare for 2005 censuses, and in **Peru** the Fund is supporting the upcoming census by managing the government-funded cost-shared census budget of $6 million. UNFPA had a major involvement in the first-ever census in **Timor-Leste,** making innovative use of the global positioning satellite technology for mapping households in a country without an address system. Country-level census interventions supported by the Fund are a prelude to the 2010 round of censuses. UNFPA has been active in 2004, liaising with Governments, United Nations technical agencies and donors to advocate support for the censuses that will be implemented in and around 2010. Notably, the priorities that UNFPA was pursuing globally in 2004 were in line with the recommendations of the thirty-sixth session of the Statistical Commission attended by the heads of statistical offices of 75 countries in March 2005.

83. A census provides vital information for a national database, and the monitoring of specific indicators of national development plans, ICPD, MDGs and PRSPs, requires in-depth analysis of relevant census data. In 2004, UNFPA paid increasing attention to post-census data analysis, particularly in Africa. In **Gambia**, **United Republic of Tanzania** and **Uganda**, the Fund helped Governments analyse the results of previous censuses, and advocated for increased use of the data. Resource mobilization for censuses is a crucial area where UNFPA plans to strengthen its leadership role and step up advocacy and partnership-building efforts.

84. Demographic, reproductive health and technical surveys. These surveys provide reliable and specific information for policy and programme planning, monitoring, and evaluation and are especially valuable when adequate national data collection systems do not exist. In 2004, UNFPA supported 14 countries in conducting demographic health surveys (DHS) and reproductive health surveys (RHS). In **Ethiopia,** UNFPA helped to mobilize nearly $1 million to support a DHS. In **Ecuador** the Fund has been effective in advocating with donors to mobilize political support and financial resources for a DHS. In this area, UNFPA not only provided direct financial assistance but also built national capacity for the analysis, dissemination and use of the data.

85. Besides DHS and RHS, UNFPA provided assistance or contributed to thematic surveys, research and studies focusing on youth, gender and culture, migration, and aging in more than 30 countries. In **Thailand**, the Fund supported collection of data on older persons affected by HIV/AIDS, based on which a model package of services will be developed. In **Myanmar**, UNFPA funded the first-ever national survey on adolescent reproductive health issues. In **Viet Nam**, UNFPA supported a survey focused on the health status of internal migrants, to help the Government design policy responses. For the first time, *The State of African Population Report* was published with support from UNFPA and endorsement of the African Union during the Summit of African Heads of State and Governments in Maputo, in July 2004. Based on its success, the African Union decided to publish the report every two years.

86. Databases and monitoring systems.[23] Country offices reported a marked increase in the number of countries with one or more national sex-disaggregated population-related databases, i.e., from 50 in 2002 to 74 in 2004, with another 15 being developed in 2004. This change reflects both improved reporting by the country offices as well as an actual increase in the availability of databases to be used in development planning, monitoring, and evaluation purposes. UNFPA has been consistently and increasingly contributing to this process. In 2004, 16 country offices reported substantial involvement in establishment of databases, elaboration of indicator frameworks, and setting up national or sectoral monitoring systems to track progress in implementation of national policies, PRSPs, and MDGs.

[23] MYFF SRF indicator.

However, about one-third of the country offices reported the need to expand access to the databases for utilization by both policy planners and civil society organizations, especially for monitoring and accountability purposes. UNFPA will work with Governments and other United Nations partners in the DevInfo initiative to support MDGs tracking and to make data accessible through advocacy as well as by promoting modern technologies in data management, such as internet-based systems and databases.

87. In **Fiji** and **Zimbabwe** the Fund was taking the lead in bringing together government bodies and the United Nations agencies to establish national development indicator databases. UNFPA was working with several countries, including **Turkey** and **Albania** to establish databases that are compatible with European Union standards. The reports indicate increased UNFPA involvement in setting up databases for poverty reduction strategies and monitoring systems in several Commonwealth of Independent States (CIS) countries, such as **Azerbaijan** and **Armenia**. The analysis also shows that UNFPA has been working both at the national and provincial levels. Availability and use of geographically disaggregated data is extremely important for development of targeted policies, and monitoring of localized MDGs. Examples include support to an integrated system of indicators for development at the provincial level in **Panama** with updated MDG and socio-demographic indictors, including for ageing, HIV/AIDS, human development, science and technology, and quality education. Kenya, Cameroon and Benin are also developing, with UNFPA support, databases for monitoring the MDGs. In Cambodia, urban and rural areas were mapped to assist in the formulation of local development policies.

Table 4: Availability of sex-disaggregated, population-related database [a]

	2002	*2004*	*Under development*
National database of sex-disaggregated, population related data, with plans to update at regular intervals	50	74	15

[a] Sample: Number of reporting country offices in 2002 = 81 and in 2004 = 93.

Progress on Outcome (v): National, subnational and sectoral policies, plans and strategies take into account population and development linkages

88. Linking population issues to poverty reduction. In 2004, UNFPA focused on the incorporation of population dimensions into national development plans, including PRSPs. Forty-three country offices reported undertaking interventions to make explicit population and poverty linkages; building capacity of civil society groups to advocate for population issues; and the incorporation of population and poverty linkages in the formulation of national development plans and policies. UNFPA is deeply involved in assisting Governments to link population issues to poverty in PRSPs currently under development.

89. UNFPA has intensified its advocacy efforts linking population and poverty. From a sample of 62 national development plans adopted since 2000 (including PRSPs), 26 explicitly incorporate population and poverty dimensions. In **Gambia**, the national population policy was revised to incorporate HIV/AIDS, ageing, and poverty issues together with population and MDG indicators. The five-year development plans of **Oman**, **Turkey** and **Yemen** reflect the ICPD goals and MDGs. The PRSP in **Nicaragua** includes a population-based strategy for delivering services to rural communities with the highest poverty rates. In **Eritrea**, national policies for poverty reduction, food security, education, STIs/HIV/AIDS, and gender have been formulated with UNFPA support. In **India, Kazakhstan**, **Syrian Arab Republic**, **Uganda** and **Viet Nam**, among others, UNFPA strengthened the knowledge and skill base of policy planners and technical staff to integrate population variables, including reproductive health, ageing, gender, and migration, into development planning. In **Mongolia**,

a training programme on population, gender and development was designed and included in the curriculum of the Management Academy.

90. Support to the formulation and implementation of population policies. In 2004, UNFPA continued to play a leading role in supporting the formulation, operationalization and implementation of national population policies. Key achievements in this area were reported in several countries in Asia. **Cambodia** launched its National Population Policy and is formulating an action plan for its implementation. In **Indonesia**, **Lao People's Democratic Republic** and **Mongolia**, UNFPA helped the Governments revise population and development policies to strengthen gender and human rights aspects, among others, while in **Viet Nam**, the Government and the Fund have been preparing for the review of the 2001-2010 Population Strategy implementation. UNFPA has also been supporting initiatives at the provincial level. In **Papua New Guinea**, the Fund assisted 15 provinces to prepare provincial and sectoral population action plans aligned to the national population policy. With UNFPA advocacy, the government of Morobe province pioneered budgetary support for the operationalization of its plan. UNFPA will assist other provincial governments in Papua New Guinea to scale up this initiative and sustain the implementation of the national population policy.

91. Research has been part of the strategy of expanding the knowledge base in population and development issues. In **Brazil**, UNFPA collaborated with a public research association in studies on migration, human reproduction, gender, as well as the linkages between population, environment, health and employment. The results were presented at the first Latin American Congress on Population Studies. In three states in **Mexico**, in-depth studies on different aspects of migration flows have been conducted with the Fund's assistance. The results will feed into development of an integrated model for dealing with international migrants. In **Bangladesh**, policy research studies were carried out to increase understanding of the levelling of fertility rates observed in the last years.

Gender

MYFF Goal 3: Gender equality and empowerment of women are achieved

92. Achieving gender equality and empowering women are indispensable to achieving the MDGs. Gender issues are mainstreamed throughout UNFPA programmes in both reproductive health and population and development areas. In addition, gender issues serve as the sole focus of programmes and advocacy to combat gender-based violence and to remove discriminatory legislation. Partnerships with civil society organizations and international and national agencies are an essential part of the UNFPA approach to promoting gender equality. With regard to MYFF goal-level indicators, there has been notable progress in the last decade in female education, literacy, and participation in civic life, in many countries and regions, but discrimination remains high in certain regions, countries, or in pockets of poverty or social marginalization within countries.

Progress on Outcome (vi): Institutional mechanisms and sociocultural practices promote and protect the rights of women and girls and advance gender equity.

93. In 2004, UNFPA offices in 56 countries reported the existence of national or subnational mechanisms to monitor and reduce gender-based violence,[24] and a further 20 indicated that such mechanisms were under development. The nature of mechanisms reported was wide-ranging, although a significant proportion comprise legislative provisions, particularly in Latin American and Caribbean

[24] MYFF SRF indicator.

countries[25]. Most mechanisms were regarded by country offices as being reasonably effective in monitoring and reducing gender-based violence but few operate at the subnational level, meaning that attention should be paid to introducing mechanisms at the local levels, especially the community level. Country office involvement in advancing mechanisms to monitor and reduce gender-based violence was assessed as modest. However, country offices had a significant contribution in the design of newly established mechanisms. UNFPA will intensify support to mechanisms to reduce gender-based violence.

94. Management of the consequences of gender-based violence in reproductive health services. Clear protocols, guidelines, and training tools are essential to ensure the provision of quality services to manage the health consequences of gender-based violence, with full respect to women's rights. The use of protocols for gender-based violence, while less advanced than for other reproductive health services, has greatly expanded, particularly in the last two years. Whereas in 2002, 19 country offices reported the existence of protocols for managing the health consequences of gender-based violence, 55 country offices confirmed their existence in 2004. This has been mirrored by a substantial increase in UNFPA support to protocol development in this area, which grew from 11 country offices in 2002 to 50 in 2004. As noted for sexual and reproductive health protocols, more attention needs to be focused on monitoring and evaluation to ensure the quality of services as they are scaled up.

95. Many country offices reported on their specific contributions to gender-based violence prevention policies and mechanisms. **India**'s experience demonstrates how strengthening the knowledge base can feed into advocacy. In India, UNFPA supported the development of management information systems on gender-based violence that produced accurate and detailed data on violence against women; the issue of preventing gender-based violence is now centre-stage in the state of Madhya Pradesh. Eight country offices reported playing a leading role in the efforts to combat gender-based violence, either chairing a working group or multisectoral committee, or being designated by the Government as the lead agency: **Burundi**, **Cape Verde**, **Central African Republic**, **Djibouti**, **Panama**, **Sudan**, **United Republic of Tanzania** and **Timor-Leste**. In the **Central African Republic**, UNFPA coordinated the Joint Initiative on Sexual Violence with several ministries, national and international NGOs and United Nations agencies. As a result, decision makers have committed to developing a legal framework to designate sexual violence as a war crime. In **Turkey**, the State Ministry launched a media campaign with UNFPA support, which was the first step of a long-term programme on prevention of violence against women. The Turkish Football Federation ensured that all the teams wore t-shirts with the campaign logo and carried banners with messages of "stop violence against women" during football matches played on three days in December.

96. Female genital cutting. In 2004, UNFPA developed a knowledge asset on female genital cutting. Based on a request from the World Bank, UNFPA provided technical support to conduct a needs assessment on female genital cutting in **Somalia**. The World Bank and UNFPA have jointly published the findings. Programmes in **Eritrea** and **Kenya** scaled up community-based IEC efforts, while in **Djibouti**, five workshops with religious leaders built a consensus to eliminate female genital cutting, in preparation for a subregional conference in 2005 with African and Arab countries. **Kenya** has implemented innovative, culturally acceptable alternatives to eliminate these harmful practices by establishing safety nets for girls who have refused to be circumcised, conducting reconciliation activities with parents and communities, and promoting alternative rituals to female genital cutting

[25] Many national laws to combat gender-based violence were approved following the ratification by countries of the 1994 Inter-American Convention to Prevent, Punish and Eradicate Violence against Women.

97. Discriminatory provisions against women and girls removed from national and subnational legislation.[26] This indicator tracks the elimination of legislative barriers to gender equity and women's empowerment. According to country office reports, discrimination against women and girls in statutory and common/judicial law is most prevalent with regard to access to economic resources[27]. Discrimination exists in statutory and/or common/judicial law in the four other areas assessed and is significantly more prevalent in religious law, and especially so in customary law.

98. Many UNFPA country offices reported significant involvement in supporting efforts to eliminate discrimination against women and girls. Legislative advances include the following: **Afghanistan** passed a new constitution guaranteeing equal rights for men and women, and ratified the Convention for the Elimination of all Forms of Discrimination Against Women (CEDAW). **Colombia** ratified the Optional Protocol to CEDAW. The Women's Ministry and local women's NGOs in **Mozambique**, with support from UNFPA, passed a new family law that gives women equal rights; gender-related aspects of the law were incorporated into the PRSP. In **Burundi**, with financial support from UNFPA, the Association of Women Jurists has drafted a law on marriage and inheritance, which would allow women more access to the ownership of resources, particularly land. This law is in the final stages of approval. In the **United Republic of Tanzania**, parliamentarians and NGOs trained, with UNFPA support, in gender and reproductive rights successfully advocated for eliminating from the law a jail sentence for pregnant girls. In the **Dominican Republic**, the UNFPA country office and NGO partners successfully advocated to eliminate discriminatory provisions in the proposed new penal code.

99. Civil society partnerships actively promoting gender equality, women and girls' empowerment and reproductive rights.[28] Strengthening the role of civil society in promoting women's empowerment and reproductive rights is prioritized in all UNFPA programme areas. Reporting in 2004 indicated that a diversity of movements, alliances, coalitions, networks, and multisectoral committees were functioning in over 80 per cent of the countries where UNFPA has programmes. Within such partnerships, women's organizations are reportedly the best represented, followed by United Nations and government agencies, with much less participation by youth and pro-poor interest groups. Given the existence of partnerships, the immediate challenge is to strategically position such partnerships and to take advantage of the opportunity they present for advancing women's empowerment and reproductive rights, particularly in national policy development. Fifty country offices reported significant involvement in a variety of interventions to strengthen civil society partnerships, including building the capacity of NGOs for advocacy.

100. Women's empowerment advocacy. At global, regional and country levels, UNFPA is active in advocating for gender equity in partnerships surrounding PRSPs, SWAps in health, and MDG reporting, as well as in the implementation of reproductive health programmes. UNFPA is also engaged with government officials and parliamentarians who are committed to work for gender equity. In Africa, UNFPA has supported the establishment of a regional network of African women ministers and parliamentarians that consists of active national networks in at least 45 African countries. The network's primary focus is to advocate for the implementation of the ICPD Programme of Action as well as for the formulation and enforcement of gender-sensitive legislation. In **Senegal**, for example, UNFPA has a strategic advocacy partnership with the Parliamentarian Network on Population and

[26] MYFF SRF indicator.

[27] Defined as access to, and control over, economic resources, including land, property rights, and women and girls' right to inheritance, credit and traditional savings schemes. The four other areas assessed are: discrimination in access to health, including reproductive health, information, education and services; discrimination in access to education and vocational training programmes; discrimination against women and girls with STIs/HIV/AIDS, and their right to access the information needed to prevent further transmission of STIs/HIV/AIDS; and treatment and care, free from discrimination.

[28] MYFF SRF indicator.

Development. Together, they have worked towards creating an enabling environment for the voluntary elimination of practices harmful to girls' and women's health. In 2004, UNFPA strengthened its partnerships with associations of women parliamentarians, judges or lawyers in numerous countries, including **Cape Verde**, **Côte d'Ivoire**, **Democratic Republic of the Congo**, **Ecuador**, **Ethiopia**, **Guinea-Bissau**, **Kenya**, **Sao Tome and Principe** and **Sierra Leone**.

101. Training in advocacy on gender and reproductive rights issues – whether for civil society organizations, government officials, or service providers – is one of the most frequent activities supported by UNFPA at the country level. Support for capacity-building includes the production of educational and advocacy materials in local languages. In the **United Republic of Tanzania**, for example, UNFPA was selected by the Government as the lead agency to help the Ministry of Community Development, Gender and Children to mainstream attention to gender equity at the national level. UNFPA will continue to invest in capacity-building strategies – particularly in training and technical assistance – and will undertake evaluations to examine the sustainability of these efforts.

IV. MANAGING FOR RESULTS: STRENGTHENING ORGANIZATIONAL EFFECTIVENESS

102. Strengthening organizational effectiveness is an ongoing process at UNFPA and 2004 saw further progress towards a more robust results-based management culture. Progress was made in positioning UNFPA as a leader in assisting countries in implementing the ICPD Programme of Action and contributing to the achievement of the MDGs. A measure of this leadership was the success in mobilizing necessary resources to implement the Fund's mandate. The adoption of the country office typology and the introduction of the new system of staff performance appraisal and development, combined with closer attention to the quality of programming and with a stronger accountability system of financial planning and monitoring, have boosted the Fund's capacity to deliver expected results. A remaining challenge for UNFPA is to further strengthen its programme management functions, particularly with regard to monitoring and evaluation, the backbone of a results-based approach. Meanwhile, implementing the country office typology is strengthening country office capacity for continued improvement in programme management.

103. Leadership role. One of the ways UNFPA will assess its leadership in the population and reproductive health area is to look at the success in mobilizing resources for the implementation of the ICPD Programme of Action. This dimension involves the forging of global-, regional- and country-level partnerships to integrate population, reproductive health and gender concerns in development frameworks, and through these alliances to marshal a greater base of resources for the implementation of the ICPD. This report reflects on UNFPA efforts in this area, particularly at country level, and the progress reported is largely a result of the strengthened leadership efforts of the Fund to incorporate population, reproductive health and gender issues in frameworks such as SWAps and PRSPs.

104. The Fund's leadership role is assessed by core and other resources mobilized, the number of contributors to the Fund and the ability of country offices to mobilize extrabudgetary resources of $1 million or more. In 2004, the level of resource mobilization increased by $40 million over the previous year and a record of 166 donors was achieved. Membership in the "million dollar club" -- country offices that mobilized over one million dollars for the country programmes -- almost doubled.

105. Results-based quality programming. Building on progress made in the first MYFF cycle, UNFPA continued to strengthen staff capacity in strategic planning, monitoring and evaluation, as well as build the capacity of national counterparts and NGO partners in these areas. Measures of progress in programme management include greater capacity to plan strategically, to identify baselines and targets

in a timely manner, to ensure the availability of data and to develop and implement adequate monitoring and evaluation systems.

106. During the course of the year, a series of workshops on results-based planning, monitoring and evaluation took place with staff from headquarters, CSTs and country offices in all regions. These exchanges brought out critical issues that need to be addressed to strengthen the results orientation of the Fund's programming and culminated in a quality assurance plan for headquarters divisions to provide more strategic support for programme management at the country level. In line with this, UNFPA initiated the preparation of a meta-evaluation focusing on the quality of the Fund's evaluation practices with a view to improving them.

107. Increased efforts were made by country offices themselves to improve programme planning and formulation within the context of the United Nations joint programming, often with assistance provided by CSTs, to improve staff skills and those of implementing partners in strategic planning. Additionally, because of the focus on monitoring and evaluation for measuring progress towards the MDGs, these essential components of results-based management are gradually being institutionalized in country programmes. Data availability, however, continues to be a challenge. UNFPA will continue to support strengthening the capacity of national counterparts in results-based monitoring and reporting.

108. Excellence in human resources. The cornerstone of the Fund's human resources strategy, detailed in an earlier report to the Executive Board (DP/FPA/2002/11), is an organizational competency framework that integrates all human resource systems, in particular, performance management and promotion, staff development and learning, recruitment and rotation, and human resource planning. Competency-based assessment tools are now being used routinely as part of recruitment and selection processes.

109. The new country office typology, piloted in 2003, was further implemented in 2004 with all country offices completing the process of configuring their office structure based on the new typology. The UNFPA Division for Human Resources continued to manage the ongoing implementation of the typology by assisting with job matching, recruitment and managed separations. Fifty-nine country offices (53 per cent) had, by the end of the year, fully implemented the typology and another 50 country offices were concluding the process with filling new posts or re-staffing managed separations.

110. Within the context of the typology, Operations Manager positions were established in 44 country offices and the Fund's Learning and Career Management Branch conducted the first learning workshop for operations managers to build their capacity and understanding of UNFPA operations and programmes. The typology implementation also resulted in an increase in the number of National Programme Officer core posts from 170 to 225. Feedback received from many country offices indicate that the implementation of the typology has resulted in more human resource strength for effective programme management.

111. The new performance appraisal and development system was also implemented in 2004. Built on the competency framework, the system aims at enhancing performance and accountability of UNFPA staff. It is a results-based system in which outcomes and targets are clearly stated, enabling staff to plan and monitor their work. The Learning and Career Management Branch carried out targeted learning activities at each key stage of the performance appraisal and development system process throughout 2004.

112. In 2004, the Fund's first Global Staff Survey revealed that three-quarters of staff are satisfied with their work, and that an even greater proportion (85 per cent) is motivated to help UNFPA achieve its goals. The Staff Survey also pointed out areas where UNFPA needs to enhance human resources management, particularly

with regard to the need to increase opportunities for career development and improve supervision and performance management, including recognition of high performers. UNFPA will address these issues in implementing its human resource strategy in 2005. Recognizing the critical importance of addressing the issue of HIV/AIDS in the workplace, UNFPA joined UNICEF in making available to all staff an interactive learning/training course providing basic information on HIV/AIDS, United Nations policies and staff rights and entitlements which include access to voluntary, confidential counselling and testing, free access to condoms and good quality confidential medical care.

113. Knowledge sharing and learning. The compilation, systematization and dissemination of knowledge, particularly in programme areas, are essential components of results-based management. In 2004, UNFPA launched seven knowledge assets on the following topics: quality of sexual and reproductive health care; SWAps; obstetric fistula; female genital cutting; emergency obstetric care; mainstreaming culturally sensitive approaches in UNFPA programming; and making a knowledge asset. Five others are under development. Knowledge assets are definitive, current and readily accessible online resources that staff can access to locate knowledge about UNFPA programming, experiences and methodologies in a specific area of endeavour. These online resources, each developed and updated by a network of staff with relevant expertise and experience, have been widely accessed and used by UNFPA staff. Reports from the field indicate that UNFPA staff in 68 offices have used at least one of the knowledge assets in support of their work in 2004.

114. Knowledge sharing is a core competency in the new UNFPA performance system and takes many forms. Country office and CST web sites, web pages and publications are also valuable tools for information sharing on lessons learned and case studies. In 2004, 55 per cent of country offices in programme countries had developed web sites or web pages, up from 43 per cent in 2002. The UNFPA Evaluation Network (EVALNET) further expanded its membership among headquarters, CST and country office staff to increase dialogue on monitoring and evaluation issues. As of year's end, 26 UNFPA offices in programme countries had staff as members of the network.

115. In 2004, UNFPA developed and launched a comprehensive electronic document and publication repository called DocuShare, based on software from Xerox and customized for UNFPA. This web-based archive fills an urgent need to cope with the massive flow of documentation within the Fund and enables staff to retrieve current and past reports, policy papers, guidance notes, project publications and evaluation findings, among others. For sharing development knowledge with staff and partners, UNFPA developed and continuously updates the Development Gateway Population and Reproductive Health Web site. The Gateway is an innovative and groundbreaking Internet initiative designed to promote sustainable development and poverty reduction through partnerships, knowledge and resource sharing. The web site is a joint initiative of UNFPA, the Development Gateway Foundation and the population community, and offers a community-built database of population information, including documents, research and projects. As of March 2005, membership in the Internet site stood at approximately 5,500 members, the majority from developing countries. Members include individuals from government and international agencies, civil society and non-governmental organizations, the media and academia.

116. Accountability systems. Accountability, both for achieving results and for financial accounting, is the backbone of effective management and is mainstreamed throughout all dimensions of the results-based management from resource mobilization, quality programming, implementation of human resources strategies, to knowledge sharing and learning. Organizational units are held accountable for implementing their office management plans, which are based on annual organizational priorities. The latter are formulated within the context of the medium-term strategic and managing-for-results frameworks of the MYFF. The performance appraisal and development systems in turn are based on

office management plans and hold supervisors and staff accountable for achieving their own outputs. Thus, the UNFPA accountability system consists of a chain of results stretching from the MYFF to individual deliverables.

117. In its efforts to improve accountability, on 1 January 2004, UNFPA launched its Enterprise Resource Planning (ERP) system with a new software to coordinate financial, programme and human resources and to increase accountability, efficiency and transparency in business processes. By the end of the year, the first phase of the roll-out was complete. In order to provide requisite support to all staff both at headquarters and in the field, several guidance notes were issued and training sessions were organized for different modules of the new ERP system. Seven regional training sessions were organized in Africa alone during the third quarter of the year, in addition to in-country training.

118. Periodic internal audits are an important element of oversight to ensure compliance with the Fund's regulations, rules, policies and procedures covering the organization and staffing, financial operations, personnel administration, general administration, programme operations and office automation of headquarters and country offices, as well as the effective, efficient and economic use of resources. In addition, the audits review conformity of the expenditures with the purpose for which funds were appropriated and the regularity of the receipt, custody, expenditure, accounting and reporting of financial resources. The UNFPA Audit Services Branch increasingly follows a risk assessment approach for the selection of entities to audit. Of the 18 offices audited in 2004, the results indicated that four offices were satisfactory, 10 offices were partially satisfactory and four offices were deficient. The Geographical Divisions and the Audit Services Branch monitor the implementation of the audit recommendations and report the progress made towards implementation to the Oversight Committee. (See also DP/FPA/2005/9 for further information on UNFPA internal audit and oversight activities in 2004.)

119. Assessing progress in managing for results. UNFPA is fully committed to track progress of its organizational effectiveness through the managing-for-results framework. For this purpose it has identified 11 lead indicators that reflect five key managing-for-results dimensions presented in the 2004–2007 MYFF. These indicators will be used to monitor the Fund's effectiveness and will be reported on in the MYFF cumulative report in 2007. Table 5 presents the managing-for-results dimensions and indicators with their respective baselines for 2004.

Table 5: Lead indicators of the managing-for-results framework

	2004 Baselines [a]
Resource mobilization	
Regular and other funds mobilized during the current MYFF period	Regular funds: $331.6 million Other resources: $174.5 million *Total*: $506.1 million
Number of countries and organizations that contribute to UNFPA regular and other resources	166
Number of country offices that have secured co-financing pledges for $1 million or more during the current MYFF	17

Results-based quality programming	
Proportion of country offices with a country programme that have baseline data for at least 75 per cent of their output indicators	25%
Proportion of country offices with a country programme that have implemented at least 75 per cent of their field visit monitoring plans [b]	61%
Excellence in human resources	
Proportion of country offices with a country programme rating their professional staff as proficient in results-based management	54%
Proportion of country offices with a country programme reporting that national professional staff completed at least 75 per cent of activities in their annual staff development plan	54%
Knowledge sharing and learning	
Number of knowledge assets on priority topics developed and used	7
Proportion of professional staff completing a learning programme provided by Learning and Career Management Branch [c]	43%
Accountability systems	
Proportion of internal audits with satisfactory or partially satisfactory rating	78%
Proportion of country offices that conducted mid-year and/ or annual reviews of office management plans	89%

[a] Percentages out of those reporting data for 2004.
[b] Overall, 78 per cent had such a field visit monitoring plan in 2004.
[c] Professional staff in 100 and 200 series type of contract.

V. IMPLEMENTING THE INTEGRATED RESOURCES FRAMEWORK

120. The ICPD Programme of Action estimated that $18.5 billion would be needed in the year 2005 to implement the costed components of programmes in reproductive health, including family planning, maternal health and prevention of STIs and HIV/AIDS, as well as basic data collection and analysis of data. Additional resources would be required to strengthen health systems, emergency obstetric care and HIV/AIDS treatment and care. Donor assistance and domestic expenditures amounted to slightly more than $15 billion in 2003 as reported to the Commission on Population and Development (see E/CN.9/2005/5). This makes reaching the ICPD target of $18.5 billion in 2005 possible if both donors and developing countries continue to increase funding as in recent years. It is questionable, however, whether the $18.5 billion would be sufficient to cover ICPD implementation as health care costs have risen and the HIV/AIDS crisis is far worse than anticipated in 1994. In addition to addressing the need to combat HIV/AIDS, the international community must also consider the funding necessary to address the existing unmet reproductive health needs.

121. UNFPA income from regular resources reached an all-time high of $331.6 million in 2004. The current projections for 2005 are $360 million. Projections for 2006 and 2007 are also higher than contained in the MYFF 2004–2007. The income projections from other resources remain at $320 million for the 2004–2007 period. While the income from regular resources for 2004–2007 was earlier estimated as $1.2 billion in the MYFF 2004–2007, it is now estimated as $1.4 billion as shown in table 6. This is $231 million or 19 per cent higher than the income projections used in the MYFF 2004–2007. This income base is also being used for the estimates for the biennial support budget for 2006-2007, which will be submitted to the Executive Board for consideration at the second regular session in September 2005.

Table 6. Approved MYFF requirements 2004–2007 and proposed revision (in millions of dollars)

	Approved in MYFF 2004–2007[a]	Proposed revision

Regular resources	$	%	$	%
Country programmes	640	53	800	56
Intercountry programme	124	10	155	11
Technical Advisory Programme	76	6	76	5
Total programme	841	70	1,031	72
Net biennial support budget (BSB)	318	26	357	25
Miscellaneous, ERP and Security	45	4	46	3
Total BSB and miscellaneous	363	30	403	28
Total regular resources	1,203	100	1,434	100
Other resources				
Programme and other	320		320	
All resources	1,523		1,754	

N.B. Totals may not add up due to rounding. All figures for 2004 are provisional.
[1] See document DP/FPA/2004/4, table 1.

122. Given these increases in the income projections, UNFPA is proposing to revise the resource requirements for 2004–2007. UNFPA is proposing to increase the programme resources for the 2004–2007 period to the amount of $1,031 million, which is $190 million or 23 per cent higher than the amount initially foreseen in the MYFF 2004–2007. Country programmes would receive $800 million, which is $160 million or 25 per cent more than the amount foreseen in the MYFF 2004–2007; while the intercountry programme would receive $155 million, which is $31 million or 25 per cent more than the amount foreseen in the MYFF 2004–2007, and the Technical Advisory Programme would receive the same amount as previously foreseen. The biennial support budget would increase from $318 million to $357 million, while the share for the biennial support budget for the 2004–2007 period would decrease from 26 per cent to 25 per cent of regular income.

123. By using the Atlas software, UNFPA is better able to analyse expenditures by MYFF goals and outcomes. Provisional programme expenditure data for regular resources shows that in 2004, 63 per cent of the resources went to reproductive health, 21 per cent to population and development, 6 per cent to gender and 10 per cent to programme coordination and assistance. It should be noted that Atlas only captures the main focus of each project, the actual expenditures for gender are higher but difficult to assess, as gender issues have been mainstreamed in other areas. The MYFF outcome receiving the largest share of resources in 2004 was "access to comprehensive reproductive health services increased" which received 38 per cent of regular resources, followed by the outcome "national, subnational and sectoral policies, plans and strategies take into account population and development linkages" which received 15 per cent of regular resources in 2004. It should be emphasized that these figures are provisional, to be confirmed when the 2004 financial closure is finalized.

124. Achievement of the MDGs is not possible without increased support for the implementation of the ICPD Programme of Action. While the international donors have increased their assistance to HIV/AIDS programmes, increases in resources are needed in all other areas as well. UNFPA is working with all countries to continue to expand its donor base, increase the number of multi-year pledges and, in particular, to increase the regular resources contributions to UNFPA.

VI. LESSONS LEARNED AND STRATEGIC CONSIDERATIONS

125. The 2004–2007 MYFF SRF set the organizational results at the goal and outcome levels; setting results at a higher level covers most of the outputs under UNFPA programmes and highlights linkages between the three levels of results. At the same time, this introduced a major limitation since up-to-date and country-disaggregated data to assess progress at the quantitative goal and outcome levels has not been fully available. It also raised issues of attribution and aggregation of results as discussed earlier. The inclusion of qualitative outcome indicators and the decision to keep collecting information on several robust output indicators from the first MYFF, coupled with a better quality of reporting from UNFPA units, helped to provide evidence of results ascribable to UNFPA. The above-mentioned issues would be addressed when preparing the next MYFF.

126. Many more UNFPA country offices are becoming engaged in broader national development efforts and partnerships (including PRSPS, SWAps, and MDGRs) to mainstream the ICPD agenda and the MDGs. The lessons learned indicate that the Fund needs to address several constraints to position itself as a development partner whose contribution adds value to poverty reduction processes. Firstly, UNFPA needs to further strengthen the capacity of its professional staff to better integrate reproductive health, population and gender issues in poverty reduction processes. Secondly, it is necessary to advocate with participating donors and Governments to provide opportunities for UNFPA involvement in these nationally-led processes.

127. Effective advocacy has led to important advances in youth-related and gender equality policies, as well as increases in national budgets for reproductive health commodity security. However, it is clear that the passage of policies is only the first step in a longer-term process leading to increased levels of expenditures in the area of reproductive health; more effective programmes dealing with gender issues; and specific programmes that deal with youth and adolescents needs. UNFPA will continue to follow through and support Governments in the implementation of these policies.

128. Continued investment in building national capacity to collect sex-, age-, income-, rural and urban-disaggregated data, as well as the analysis and utilization of such data, must be a priority not only for UNFPA but also for the international development community to track country-level progress toward achieving the MDGs. Improving accessibility to existing data is also crucial for increasing its utilization by both policy planners and civil society organizations, especially for monitoring and accountability purposes.

129. As a basic step in the adoption of results-based management, UNFPA programmes will increase support for setting up monitoring and evaluation systems and programme databases in counterpart organizations. Innovative programme strategies and models need to be documented, and successful ones should be scaled up by Governments and other development partners.

130. UNFPA is fully committed to continue strengthening the results-based management culture in the organization. The Fund will continue to improve staff skills and abilities, strengthen the technical capacities of country offices, promote knowledge sharing and learning across the organization, improve accountability systems, and improve both the quality of programming and the quality of the technical assistance provided to Governments and other development partners.

VII. ELEMENTS FOR A DECISION

131. The Executive Board may wish to:

(a) Take note of the report of the Executive Director for 2004 (DP/FPA/2005/7, Parts I to II) and welcome the progress made by UNFPA during the first year of the implementation of the 2004–2007 MYFF, noting the Fund's contribution to the achievement of the MYFF strategic results;

(b) Underscore the efforts made by UNFPA to implement the ICPD Programme of Action and the key actions for the further implementation of the ICPD Programme of Action (ICPD+5) as essential contributions to the achievement of the MDGs;

(c) Endorse the revision of the MYFF integrated resource framework for the period 2004–2007, as proposed in the present report (DP/FPA/2005/7, Part I);

(d) Encourage UNFPA to further integrate the ICPD agenda into country-led frameworks such as SWAps, PRSPs, health sector reforms and other national development plans and policies;

(e) Emphasize the need to continue forging innovative partnerships among development partners, Governments, civil society organizations and the private sector to achieve the ICPD goals and the MDGs;

(f) Request UNFPA to continue to bring reproductive health and rights and gender perspectives into the UNDAFs and MDG reports;

(g) Recognize the progress being made to improve the Fund's organizational effectiveness and encourage UNFPA to continue developing its managing-for-results framework and to present progress in the cumulative report due in 2007;

(h) Encourage UNFPA to continue to track progress on its MYFF in terms of the goals, outcomes and indicators in the MYFF strategic results framework.

ANNEX 1- 2004–2007 MYFF Strategic Results Framework: UNFPA Goals, Outcomes, Indicators and Strategies

POVERTY REDUCTION			
GOALS	GOAL INDICATORS	OUTCOMES	OUTCOME INDICATORS
(1) All couples and individuals enjoy good reproductive health, including family planning and sexual health, throughout life	a) **Maternal mortality ratio** b) Adolescent fertility rate c) **HIV prevalence among 15-24 year old pregnant women** *[UNGASS-HIV]* d) **Under-five mortality rate** e) Unmet need for family planning	(i) Policy environment promotes reproductive health and rights	a) Reproductive health and gender incorporated into: i) Poverty reduction strategies ii) Sector-wide programmes in health iii) Millennium Development Goals Reports b) National and subnational policies in place to increase the access of youth to quality reproductive health information and services c) National and subnational laws and policies in place to delay the age at marriage d) Proportion of health budget allocated to contraceptives
		(ii) Access to comprehensive reproductive health services is increased	a) Contraceptive prevalence rate (modern methods) b) **Proportion of births attended by skilled health personnel** c) **Condom use at last high-risk sex**[1] *[UNGASS-HIV]* d) Proportion of clients with sexually transmitted infections who are appropriately diagnosed, treated and counselled *[UNGASS-HIV]* e) Caesarean sections as a proportion of all births[2]
		(iii) Demand for reproductive health is strengthened	a) Proportion of women who have the final say in decisions about their own health care b) National and subnational mechanisms that advance civil society participation in planning and monitoring quality reproductive health services c) **Proportion of the population aged 15-24 with comprehensive correct knowledge of HIV/AIDS**[3] *[UNGASS-HIV]*
(2) Countries address interactions between population dynamics, sustainable development, and poverty, including the impact of HIV/AIDS	a) Life expectancy at birth, by sex b) **Proportion of population below $1 (PPP) per day** c) Poverty headcount ratio[4] d) Age dependency ratio[5]	(iv) Utilization of age- and sex-disaggregated population-related data is improved	a) Sex and age disaggregated data from national and subnational databases are used to monitor national development plans
		(v) National, subnational and sectoral policies, plans and strategies take into account population and development linkages	a) Population and poverty linkages explicit in national development policies and plans and poverty reduction strategies
(3) Gender equality and empowerment of women are achieved	a) **Ratio of girls to boys in primary and secondary education** b) **Literacy rate among 15-24 year old females** c) **Proportion of seats held by women in national parliament**	(vi) Institutional mechanisms and sociocultural practices promote and protect the rights of women and girls and advance gender equity	a) National and subnational mechanisms in place to monitor and reduce gender-based violence b) Discriminatory provisions against women and girls removed from national and subnational legislation *[Beijing +5]* c) Civil society partnerships actively promoting gender equality, women and girls' empowerment and reproductive rights
STRATEGIES *Advocacy and Policy Dialogue - Building and Using a Knowledge Base - Promoting, Strengthening and Coordinating Partnerships – Developing Systems for Improving Performance*			

Indicators in bold are Millennium Development Goal (MDG) indicators

[1] Proportion of the sexually active population aged 15-24 reporting the use of a condom during last sexual intercourse with a non-regular partner in the last 12 months.

[2] Serves as a proxy for access to Comprehensive Emergency Obstetric Care.

[3] Proportion of the population aged 15-24 who correctly identify the two major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner), who reject the two most common local misconceptions about HIV transmission, and who know that a healthy-looking person can transmit HIV.

[4] Proportion of the population below the national poverty line. The MDGs specify that for monitoring country poverty trends, indicators of national poverty should be used, where available.

[5] The ratio of people of non-working age (0-14 and 65+) to those of working age, used to document broad trends in age composition and dependency burden.

ANNEX 2

MYFF 2004–2007 SRF goals and indicators and their links to targets and benchmarks of ICPD and ICPD+5, other international conferences, and the Millennium Development Goals

REPRODUCTIVE HEALTH GOAL AND INDICATORS

SRF RH goal	Related ICPD goals	Related MDGs
All couples and individuals enjoy good reproductive health, including family planning and sexual health, throughout life	• **Universal access to reproductive health by 2015** • **Reduce maternal and child mortality** • **Reduce HIV/AIDS**	• Improve maternal health (MDG 5) • Reduce child mortality (MDG 4) • Combat HIV/AIDS, malaria and other diseases (MDG 6)
SRF RH indicators	Related benchmarks and targets of ICPD and ICPD+5, and other international conferences	Related MDG target
Maternal mortality ratio	**ICPD:** Reduce maternal mortality by one half of the 1990 levels by the year 2000 and a further one half by 2015	**Target 6**: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio
Proportion of births attended by skilled health personnel	**ICPD+5**: By 2005, where the maternal mortality rate is very high, at least 40 % of all births should be assisted by skilled attendants; by 2010 this figure should be at least 50 % and by 2015, at least 60 %. By 2005, 80 % of all births should be assisted by skilled attendants, by 2010, 85 %, and by 2015, 90 %	
Unmet need for family planning	**ICPD+5**: Any gap between proportion of individuals using contraceptives and proportion expressing a desire to space or limit their families should be reduced by at least 50 % by 2005, 75 % by 2010 and 100 % by 2050	
HIV prevalence among 15-24 year old pregnant women	**ICPD+5, UNGASS**: Reduce HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25 % by 2005, and by 25 % globally by 2010	**Target 7**: Have halted by 2015 and begun to reverse the spread of HIV/AIDS
Proportion of the population aged 15-24 with comprehensive correct knowledge of HIV/AIDS	**UNGASS**: By 2005, 90% of people aged 15-24 should have comprehensive correct knowledge of HIV/AIDS; 95% by 2010 **ICPD+5**: By 2005, at least 90 %, and by 2010 at least 95 %, of men and women aged 15 to 24 should have access to the information, education and services necessary to reduce their vulnerability to HIV infection	
Under-five mortality rate	**ICPD**: Reduce by 2000 the under-five mortality rate by one third, or to 70 per 1,000 live births, whichever is less; and by 2015, everywhere to below 45 per 1,000	**Target 5**: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

POPULATION AND DEVELOPMENT GOAL AND INDICATORS

SRF P&D goal		Related MDGs
Countries address interactions between population dynamics, sustainable development, and poverty, including the impact of HIV/AIDS		• Eradicate extreme poverty and hunger (MDG 1) • Ensure environmental sustainability (MDG 7)
SRF P&D indicators	Related benchmarks and targets of ICPD and ICPD+5, and other international conferences	Related MDG target
Proportion of population below $1 (PPP) per day		**Target 1**: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day **Target 9**: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources
Life expectancy at birth by sex	**ICPD**: By 2005, life expectancy at birth should be greater than 70 years, and by 2015 greater than 75 years. Where mortality levels are highest, life expectancy at birth should be greater than 65 years by 2005, and by 2015 greater than 70 years	

GENDER GOAL AND INDICATORS

SRF Gender goal	Related ICPD goals	Related MDGs
Gender equality and empowerment of women are achieved	• **Gender equity, equality and empowerment of women** • **Universal education**	• Promote gender equality and empower women (MDG 3) • Achieve universal primary education (MDG 2)
SRF Gender indicators	Related benchmarks and targets of ICPD and ICPD+5, and other international conferences	Related MDG target
Ratio of girls to boys in primary and secondary education	**ICPD**: Elimination of the gender gap in primary and secondary education by 2005, and complete access to primary school or the equivalent by both girls and boys as quickly as possible and in any case before 2015	**Target 4**: Eliminate gender disparity in primary and secondary education, preferably by 2005, and to all levels of education no later than 2015
Literacy rate among 15-24 year old females	**ICPD+5, EFA, WSSD, FWCW:** Reduce the rate of illiteracy of women and men, at least halving it for women and girls by 2005, compared with the rate in 1990	
Proportion of seats held by women in national parliament	**FWCW**: 30 % share of seats for women in national parliaments (*Millennium Task Force on Education and Gender Equality* set target to be achieved by 2015)	
Discriminatory provisions against women and girls removed from national and subnational legislation	**Beijing+5**: Create and maintain a non-discriminatory and gender-sensitive legal environment by reviewing legislation with a view to removing discriminatory provisions, preferably by 2005	

International conferences: *EFA* – World Conference on Education for All, Jomtien, 1990; *FWCW*- Fourth World Conference on Women, Beijing, 1995; *Beijing+5* - United Nations General Assembly Special Session on Women, New York, 2000; *ICPD* - International Conference on Population and Development, Cairo, 1994; *ICPD+5* – United Nations General Assembly Special Session on the review and appraisal of the ICPD Programme of Action, New York, 1999; *WSSD* - World Summit for Social Development, Copenhagen, 1995; *UNGASS* - United Nations General Assembly Special Session on HIV/AIDS, New York, 2001.

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